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Organizing Health Inequalities? Employee Driven Innovation and the Transformation of Care

Key Words: health inequality, organizational sociology, employee driven innovation, homeless health

Abstract: *This paper responds to calls for new approaches to understanding and intervening in health inequalities and in particular for attention to the processes and relations that mediate structural inequality and everyday outcomes. Our contribution focuses on the part that healthcare organizations play in this. We draw on organizational sociology, which theorizes that whilst organizational structures, cultures and practices may appear neutral - and rely for their legitimacy on this - they may, in fact, operate in the interests of some social groups and less in the interests of others. This proposition is worked through new empirical research on employee driven innovation in the UK National Health Service. In both our case studies, front-line staff working with some of the most vulnerable citizens had identified the organization of care as both part of the problem and – potentially – part of the solution. In tracing their efforts to change the organization of care, we learn more about what it might take to mobilise resources in support of those whose lives are most affected by health inequalities.*

Introduction

It is well established that individual health outcomes are shaped by social determinants – for example income, education and housing – that are unevenly distributed across the population, leading to inequalities in life expectancy and quality of life (Tudor-Hart 1971; Black 1980; Acheson 1998; Wilkinson and Pickett 2009; Marmott 2010). However, even as knowledge of the social determinants of health deepens, frustration grows over the lack of effective means to address health inequalities (Garthwaite et al 2016). Accordingly, there are calls for a step-change in health inequalities research. Elliot et al (2016) summarise these along three dimensions. First, there should be greater use of social theories to understand the mechanisms that link structural inequality to health outcomes. Second, the lay knowledge of those whose health is most affected by inequality should be integrated into strategic interventions. Third, there needs to be better understanding of the opportunities for collective action to reduce health inequalities (Elliot et al 2011).

Our response is to focus on the part that the *organization* of healthcare plays in health inequalities. We distinguish this from a focus on health care ‘systems’, which insists on the significance of funding models in shaping inequalities, as well as the distribution of funding across these systems (Baum 2016). Without questioning the importance of these issues, we focus instead on the organizational forms and practices through which healthcare is designed and delivered *within* healthcare systems, specifically within the UK National Health Service (NHS). Whilst there is some reference to this in landmark reviews of health inequality (Tudor-Hart 1970; Black 1990, Marmot 2010) there has been remarkably little attention from health inequalities research, where the focus on social determinants has largely been meant attention to factors *other than* healthcare (Graham 2004). Indeed, Hellowell and Ralston (2016) refer to ‘*the marginalisation of healthcare in the inequalities literature*’ (p.151) and suggest that organizational questions have been regarded as a distraction from the social determinants of health.

To the contrary, we will argue that organizational forms and practices contribute to producing, reproducing and diminishing social disparities (Lawrence et al 2014). Our premise is that the nature of organization is not separate from wider social relations or neutral with regard to them. This proposition is well-established in scholarship on gender and organization, which theorises

the operation of gender inequality through the design and culture of work organizations (Witz and Savage 1992; Halford et al 1996; Alvesson and due Billing 2009). The potential that we see in these theoretical resources arises from our recent study of ‘employee driven innovation’ in healthcare. We did not set out to explore health inequalities. Rather, in a context where the National Medical Director of NHS England had called on the ‘*intellectual capital*’ of NHS staff to address the challenges facing the NHS¹, we aimed to understand if and how staff were able to pursue innovation. However, it soon became clear that the employees’ driver for change in our case studies was an underlying conviction that the organization of care is iniquitous. As staff listened to the voices of vulnerable patients – the homeless and for those living in multiply deprived communities – they began to question established organizational models, and to develop alternatives. Our case studies show that the organization of healthcare is *both* part of the problem and – potentially – part of the solution. In tracing how staff tackled iniquitous health outcomes through organizational innovation we learnt, in turn, about how resources have been mobilized on behalf of those who are most affected by health inequalities.

The next section describes in more detail the elements that might be combined to generate new knowledge about the operation of health inequalities and routes to effective intervention through organizational change. Subsequently we describe our methodology and then explore two case studies. In each we describe the problematization of organizational forms and practices and the alternatives that were established. Our conclusion considers the wider implications of our research for understanding how the organization of care is implicated in health inequality and how this might be challenged.

Health Inequalities

Research on the social determinants of health has had enormous success and made disappointing progress. The weight of evidence has led to widespread agreement that health outcomes are not solely explained by biomedical factors but are significantly shaped by social and economic processes (Bouchard et al 2016; Smith et al 2016). This has informed a ‘global shift’ (Scambler 2011) in policy (WHO 2015), with the UK at the forefront (Mackenbach 2010), particularly as health inequalities were mainstreamed by the 1997-2010 Labour government. However, there remains little evidence of effective intervention. Even in the UK, the ‘social gradient’ continues to widen across the socioeconomic hierarchy, as pervasive inequalities in the social determinants of health impact health outcomes for all (NAO 2010). Establishing health inequalities as a social problem is a remarkable achievement: building on this to address the problem remains an enormous challenge (Exworthy et al 2002; Wilkinson 2016).

Perhaps this is only to be expected. Despite some narrowing over the 20th Century, economic inequality in the US and Europe is rising. Over the past 30 years, the gap between rich and poor has widened in the UK (Equalities Trust 2014). These economic inequalities continue to operate in intersections with other deeply persistent forms of inequality, especially gender and ethnicity (Annendale 2010; Bradby and Nazroo 2010; Hill 2016). In this context, the effect of UK policy initiatives has been both limited (Exworthy and Hunter 2011) and short-lived, following the

¹ Sir Bruce Keogh, BBC Radio 4 Today, 29 May 2013.

onset of the 2008 global recession and the shift in political agenda that followed the Labour Party's loss of power in 2010.

These circumstances heighten the importance of understanding what interventions might be effective in tackling health inequalities. In this context, there have been persistent calls for fresh thinking to move the debate forward. Three key points can be distilled from these (Elliot et al 2016).

First, there should be greater application of social theory to understand how health inequalities operate. Specifically, there have been calls for theoretical resources to address the polarisation of attention between broad social structures, on the one hand, and individual lives on the other,. As Baum (2009) suggests

'The causal links between the structural determinants of health and health outcomes are complex and embedded in a web of political economic and environmental and social factors' (p.432)

In UK policy terms this has focussed attention on factors beyond healthcare, for instance, employment, housing and education, underpinned by powerful data analysis presented in Black (1990) and Acheson (1998) and Marmot (2010). However, whilst these interventions point to policy fields that mediate structural inequality and individual health outcomes, they offer little theoretical interpretation of the causal mechanisms and pathways through which this happens. In particular, Scambler (2011) suggests that the extensive and well-intentioned policies of the New Labour governments were limited because they had no conceptual understanding of social structure and consequently failed to appreciate what it would take to shift the advantages embedded in the established order. At the meso-level – between claims about structure and agency – we need theoretical understanding of how existing institutional, discursive and regulatory means support structural arrangements of power (Williams 2003). This will help us to understand what needs to change, as well as the countervailing interests that might make change difficult (Exworthy and Hunter 2011).

Second, a strong case is made for the situated knowledge of those whose health is most affected by inequality (Garthwaite et al 2016). It is argued that instead of measuring pre-determined 'risk factors' or imposing a priori theoretical frameworks *'the elimination or reduction of health inequalities calls for an interrogation of what this might mean in [global] citizens' actually existing social and natural worlds'* (Scambler 2011 p.144). For this we need understanding of the complexity of lives in particular times and places. Personal narratives collapse the division between structure and agency showing how these are co-constituted in everyday circumstances and practices (Williams 2000). As Elliot et al (2016) suggest:

'As people talk of the everyday, they weave accounts of personal experience and biography with the material, social, normative and 'macro' –political processes generating inequalities.' (p.227)

As such, qualitative research, including what Garthwaite et al (2016) term 'empathetic ethnography', is key to theoretical development.

Third, there are calls for greater attention to the resources for and barriers to supporting solidarity and collective action to tackle health inequalities (Popay 2010). Whilst most sociological research on health inequality has concentrated on understanding how inequalities

come about, and/or are experienced, there is less attention to what can be done to change things. Here, there might be greater critical attention to the sources of, and potential for control over, ‘*transformatory powers*’ (Elliot et al p.231) - the resources that might be mobilised to achieve changes to reduce health inequalities – and the ‘*visionaries*’ (Scott-Samuel and Smith 2015) who can see how beyond what we have towards how healthcare might be organized differently.

In what follows, we combine these three elements to explore how the organization of healthcare shapes health inequalities and how this might be addressed to bring about change. We begin by considering theoretical approaches to organization that emphasise how structural power relations are embedded in organizational forms and practices, which are – in turn – implicated in the everyday reproduction of inequality.

Organizing Inequality

The importance of healthcare systems is well-established in health inequalities research, with the UK’s universal healthcare service, free at the point of delivery, held up as the gold standard. However, there is little discussion of if, or how, the design, culture and practices of healthcare *within* particular systems might impact on health inequalities. Indeed, in the health inequalities literature, the organization of health care disappears in the ongoing oscillation between the ‘*focus on controlling risky behaviours and a concern with the structural determinants of health*’ (Hunter and Marks 2016; 140). In both accounts, the organization of healthcare is neutral. Claims might be made from either perspective that there should be *more* provision of healthcare, especially in geographical and clinical areas most under-served and *better access* to this but attention to the organization of healthcare itself is largely absent.

In contrast, organizational sociology has become increasingly concerned with the ways in which organizations are implicated in the reproduction of social inequalities. In part this concerns the ‘outward’ looking effects of organizational actions, for example as executive pay widens the earnings gap or commercial organizations seek to shape government policy in ways that may not be in the wider interest (for example, the alcohol industry lobby on health policy). Beyond this, there is concern not just for what organizations *do* in shaping the wider world, but what they *are*: how their design, culture and everyday practices are implicated in the dynamics of inequality:

‘... how social rules, beliefs, norms, values and practices are mediated through formal organizations to create and reinforce structures of social inequality, such that often they become taken for granted’ (Lawrence et al 2014; 2)

This argument is perhaps most thoroughly elaborated in research that theorises the implication of organizations in gender inequality. Acker’s work (1990) is paradigmatic here. Acker claims that whilst organizations may appear to be gender neutral they are premised on an abstraction of both jobs and workers that idealises male career paths, lifecycles and even bodies such that women simply do not ‘fit’:

‘...the concept of a universal worker excludes and marginalises women who cannot, almost by definition, achieve the qualities of a real worker because to do so is to become like a man’ (Acker 1990; 150)

Or, at least, an approximation of the worker that is *closer* to many men’s experiences and more within their reach to perform than it is for the majority of women. In short, Acker’s argument is that the apparently neutral design of organizations is premised on deeply gendered assumptions

about the worker and his capacities that are reflected in the design of jobs (gender stereotyping presented as neutral criteria), careers (full-time, over 40 years) and hierarchies (that privilege masculinity, for instance). Notably, Acker also names the ‘disembodiment’ of work organizations as part of their gendered ‘sub-structure’, ruling pregnancy and menopause (for example) ‘out of order’ and grounds for stigma, control and exclusion.

This argument shifts the explanation for gender inequality and calls for new kinds of intervention to support greater equality. First, organizations themselves become implicated as a cause of inequality, since the abstract model is revealed to be highly gendered beneath its neutral shell. Second, it follows that achieving greater equality means more than simply including women in organizations that are already structured in systematically gendered ways. It is not that women as a social group are ‘disadvantaged’ and should be included in organizational life as it is. Rather, organizations have to change in order to redress the structural inequalities that are materialised within their structures and cultures. Rather than seeing gender at work as a problem for women – as a disadvantaged group – we see gender as a structural social problem, where the gendered sub-structure of organizations impacts on both women and men by privileging particular norms of masculinity.

All this may seem a long way from health inequalities. But consider this suggestion made in the Black Report (1980):

‘...the structuring of health institutions in accordance with the values, assumptions and preferences of the sophisticated middle class consumer ... [mean that] inadequate attention [is] paid to the different problems and needs of those who are less able to express themselves in acceptable terms and who suffer from a lack of command over resources of both time and money’

It is not, Black (1980) suggests, only a question of access to healthcare but also the nature of the healthcare that matters. For Black (1980) and, later, Acheson (1998) this was exemplified by a funding bias towards acute care that, they argued, disadvantaged those for whom greater health improvements would come from primary and preventative care, notably those in poorer communities who have been less well served by primary care (Tudor-Hart 1971). Nonetheless, in their review of recent improvements to General Practice in the worst served parts of the UK, Asaria et al (2016) show that whilst this brings health improvements for the ‘average’ patient, it does not narrow health inequalities between social groups. Bearing this in mind, let us paraphrase Acker’s argument with reference to the organization health inequalities:

*‘... organizational structure is not ~~gender~~ **patient** neutral; on the contrary, assumptions about ~~gender~~ **the patient** underlie the structures and cultures used to construct organizations ... Abstract ~~jobs and hierarchies~~ **services and systems** assume a ~~disembodied~~ **specifically embodied** and universal ~~worker~~ **patient**’*
(amended from Acker 1990; 139)

From this perspective, if the ‘average’ patient is universalised as ‘the’ patient in the organizational design and culture of healthcare organizations these organizations will serve those who deviate from the average less well. If the ‘average’ patient is premised on middle class assets, then these advantages are materialised in healthcare organizations. The problem is not that disadvantaged groups do not have access to the ‘best’ healthcare but rather that even the ‘best’ is not designed to address their needs.

We propose this argument as it emerged inductively from our research on ‘employee driven innovation’ (Høyrup 2012) in healthcare. We describe this project below before presenting our case studies, which reveal the organizational dimensions of health inequality and some attempts to tackle these.

Employee Driven Innovation: overview and methodology

‘Many of the problems which we suffer in the NHS are solvable if we use the intellectual capital of the 1.4m people who work in the service. That’s where the solution lies.’ Sir Bruce Keogh, National Medical Director, NHS England (29th May 2013, Radio 4 Today programme)

Over the past 50 years a series of top-down structural changes have been introduced into the NHS, intended to improve the service (Macfarlane et al 2011). Despite this, no ‘structural fix’ has yet resolved the challenges facing the NHS and, since the turn of the century, a new approach to has emerged emphasising the importance of local, even ‘bottom-up’ innovation as an untapped source for service improvement (Secretary of State for Health 2000; Department of Health 2011). In principle, this signals a creative approach to organizational change, recognising the limits of structural reform and the latent capacity of the workforce. However, little is known about if or how this capacity might be effectively mobilised not least in the highly regulated and resource-poor context of the NHS.

To explore this, we conducted qualitative research² from 2014-2016 to examine the circumstances where NHS staff had made effective innovations in service³. Key informant interviews with individuals from professional bodies (the British Medical Association and the Royal College of Nursing), from NHS England and the Department of Health (N=12) provided context for case study selection. These endorsed the potential for, and practice of, employee-driven innovation (EDI), but also suggested that innovation may be ephemeral, poorly recognised and hard to find. In this context, we pursued a purposive approach seeking already existing EDIs with some longevity, which allowed us to explore the motivation for and unfolding nature of the innovation in-depth and over time.

Our research comprised two main case studies: Case Study 1: (i) a community centre and General Practice in a multiply deprived inner-city area; and Case Study 2: an innovation addressing homeless health (. These cases are not representative but rather to allow us to trace the process and practice of innovation, and to learn from illustrative examples. In total, we conducted 34 in-depth interviews (and 15 in Case Study 1 and 19 in Case Study 2) with those individuals who had been central to the development of the innovation in each case and with a sample of staff across each organization. We also conducted observation of everyday activities (12 hours in Case Study 1 and 62 hours in Case Study 2⁴). Interviews allowed us to reconstruct the rationale and history of innovation and to explore how it had become embedded, including any difficulties encountered. Observations allowed us to see the everyday work that made the

²Removed for anonymity.

³.Removed for anonymity.

⁴ Case Study 2 was larger and spread across two cities so longer was spent here.

innovation work, as we spent time in team meetings, shadowing outreach work, and learning more about the services and users.

Interview transcriptions and field notes were thematically coded in regular research team workshops, during which core findings emerged from the data informed by our experience in the field. The topic of health inequalities emerged inductively in this way. At one level, this was always apparent: both innovations seek to improve health for disadvantaged groups. However, only through data analysis did the *organizational* analysis of health inequalities – as a wider systemic issue – come to the forefront. Pursuing this, we then analysed both case studies with the following questions: What problem motivated the innovation? How is the organization of healthcare part of the problem? How is the re-organization of healthcare part of the solution? In what follows we present evidence in the form of direct quotations from our case studies illustrating our findings, which are informed by our observational experience. The case studies are anonymised, as agreed for NHS Ethics approval.

Case Study 1: City Community and Health Centre

What is the Problem? City Community and Health Centre (CC&HC) was set-up to address poor health and build capacity in the local community. At local authority level, life expectancy at birth is amongst the lowest in England and there are significantly higher than average rates of diabetes, childhood obesity, smoking related deaths and tuberculosis (Public Health England 2016). The Centre is in one of the most deprived wards in one of most deprived boroughs in England, ranking particularly poorly for income deprivation, poor access to services, and for crime (London Data Store 2105). A community centre was set-up in the mid-1980s and has co-evolved since the 1990s with a General Practice, run by local doctors driven by commitment to tackling poor and ineffective local services. This was employee driven innovation expressly directed at tackling health inequalities, clearly understood through social determinants:

The Centre has a particular understanding of health, I think, which is very much rooted in the... Well, I mean, we predate Marmot⁵, but it's essentially summarised in the Marmot Thesis ...

Given this, there was a strong argument that changing healthcare alone would not solve the problem – which was conceived in terms of more fundamental economic inequalities – but also that the conceptualisation and delivery of healthcare contributed to the problem, echoing the theoretical claims outlined above, and might therefore be part of the solution.

How is Organization part of the Problem? During the 1990s a group of local GPs, new to the area, became increasingly aware that ‘*statutory services weren’t geared up to meet, or weren’t acting in a way that addressed ... people’s needs*’ (Sarah, GP). Beyond examples of poor service provision, the *conceptualisation and design* of healthcare was named in the reproduction of health inequalities in two key ways.

First, the functional separation of care within the NHS and between the NHS and social care, which may make sense bureaucratically and in terms of professional specialism, is not designed to meet multiple and complex needs. This affects anyone regardless of their socio-economic position, but for those with limited resources— low literacy, few social networks and low income – the capability to effectively navigate and coordinate services is particularly low. Whilst this may

⁵ See Marmot (2010) as a key articulation of current thinking on the social determinants of health.

impact on all service users, it is better accommodated by those with economic, social and cultural assets than those without. The case of a young mother whose terminal illness and death was marked by a series of organizational failings in health and social care became emblematic of what was wrong:

I remember thinking there's a way that we could deliver Primary Care that could start to create different models of care that would meet our patients' agendas better ... a much broader range of services a much more holistic range of services. What you do is stop them being distinct and silo-ed and you think of a way to create that for the patient, kind of a one-journey process so they're not required to jump through hoops to get to the right service' (Jack, GP)

Second, the existing organization of care further disempowered local residents as actors able to intervene in their own healthcare. This was described by a Community Centre worker, responsible for coordinating with the GPs:

We need to move away from this term 'services' ... It's essentially disempowering because you have a service provider and a receiver of those services ... It divorces the delivery and the shaping of that delivery from the community within which it is to be delivered (Tom, Community Centre)

The organization of care did not meet the specific needs of local people. More than a question of resources—important though this was—the problem was identified as one of organization:

I was seeing lots of really ill people ... and we were struggling to meet their physical health needs and doing it in a context where people's social needs were so complicated and we didn't have solutions to those at all ... we got to the point where we realised that we needed to take a different direction (Jack, GP)

How is organization part of the solution? Over the past 20 years CC&HC, has evolved as an organizational response to health inequalities in the local area, premised on a conviction that the organization is part of the problem if it is not part of the solution:

We couldn't disengage from the wider determinants of health, we had to think about how we embedded that much more in our day to day practice' (Jack, GP)

Innovation began with the community, rather than with individualised pathologies:

'How do you create a community where people can be involved and included whatever their circumstances are?' 'Our starting point was to try and say ... "let's not create a culture where people are passive recipients of other peoples' care" and "what would it look like if we were going to generate a kind of mutual environment where we all have something to give?"' (Sarah, GP)

Rather than designing services around an abstract patient, condition or service, the innovation started with local people: what would good healthcare look like from their point of view? This meant organizing beyond a clinical model:

I remember thinking "there's a way we could potentially deliver patient care that could start to create different models of care that would start to meet our patients agendas better and actually would sit us within teams of people who have the expertise that we don't have" (Jack, GP)

'The lesson is not to build health centres ... We genuinely believe you should build communities ... and within that you need to design high quality, proper, appropriate clinical spaces' (Phil, Community Centre)

This vision has led to a one-stop integrated service, delivered through a collaboration between the General Practice and a community centre, constituted as a charity: a not-for profit organization established for the public benefit. Both organizations realise added value from integrating on one site. The GPs rent premises inside the community centre, which is also increasingly active in developing social enterprises and attracting funding from government, trusts and corporate sponsors. The GPs rent provides a financial base for the centre, whilst mixed portfolio of funding allows a range of activities to grow (children's services for instance) and wider funding provides *'un-ring-fenced money ... to do exploratory, innovative work'* (Jane, Practice Nurse). Beyond this financial relationship, the collaboration between the centre and the GPs allows deep integration of activities:

'The relationship between the GPs, the nurses and the charity is quite remarkable ... It is perhaps more revolutionary than we realise ... combining general practice with this substantial community anchor organization that's delivering a whole array of community services and bringing those together in an integrated fashion is ... probably the greatest innovation that [we] have created and developed' (Tom, Community Centre)

This organizational innovation is supported by new staffing roles, including posts that seek to promote co-production of services with local residents:

'I was really keen that we appointed to a post to act as a focus for working with patients in a way that wasn't medicalising their condition, which was working with their capabilities, building stuff around community and resilience and which tried to address the power imbalances that you can often see in this sort of professional and patient relationship ... that's the heart of the stuff.' (Mark, Community Centre)

'[The] principles that came to be embedded in CC&HC as ways of working ... came to be called People before Structures, actually privileging and prioritising people and relationships with people' (Sarah, GP)

The Centre has developed integrated governance structures⁶ and working practices to embed this philosophy in daily practice. In particular, *'the thing that defines the relationship between the GP practice and the [community] centre is social prescribing'* (Sarah, GP). In addition to, or sometimes instead of, conventional clinical and pharmacological responses the GPs refer patients to a range of community activities (gardening, art or exercise for instance) that operate from the Centre. Moreover, the layout of the buildings is:

'...designed explicitly around some of our principles which were openness and relationships. How do you physically create spaces that facilitate relationships? A shared kitchen for the GP practice and the community organisation, patients and GPs having coffee together, sharing a dishwasher' (Sarah, GP)

And to a high standard that *'demonstrates through the way it looks something about how it respects and values the people who are using the service'* (Jack, GP).

Case Study 2: Side-by-Side

What is the problem? *'The average age of death in London was 40.2 years and the morbidity was appalling but no-one really knew because it's invisible'* (Liam, Consultant). Homeless people lead chaotic

⁶ Within the legal requirements of the NHS and the Charities Act.

lives with multiple morbidities of physical health, mental health and substance abuse. Few are registered with a General Practice and they *‘visit Accident and Emergency six times more often than non-homeless, [are] admitted four times as often, stay twice as long and [are] twice as sick’* (Liam, Consultant). The establishment of Side-by-Side (SBS) was driven by the very explicit relationship between socioeconomic inequality and poor health outcomes for homeless people and the conviction that – whilst it will not solve the fundamental causes of inequality – changing the organization of healthcare can reduce the degree of inequity in health outcomes experienced by homeless people. SBS was set up in 2009 by an NHS Consultant, Liam, who was profoundly affected by witnessing the death of a recently discharged homeless man outside a London hospital. To develop the innovation Liam drew on the experience of a GP, Neil, who had pioneered homeless health in another city over 20 years. SBS is a charity working within the NHS – which is its only customer. Its success has attracted others around the country who have set up similar initiatives under the SBS umbrella. Our case study included London SBS, which operates within a major hospital, and a regional SBS, run from a GP practice and funded through the NHS and the Local Authority.

How is organization part of the problem? Accident and Emergency is the most accessible part of the healthcare system – open to walk-in patients 24/7 – but is not designed or resourced to deal with the homeless healthcare

‘You get very narrow medical reductionist models, especially in A&E and acute medical wards it’s very snappy “will you get this man out of here”. It’s very protocol driven ... “right, I’ve made my decision: he doesn’t need to be in hospital any more” which is true but it’s nobody’s job to figure out what happens next ... nobody’s taking the overview of what is the right thing to do: everybody’s just looking at their bit of the jigsaw’ (Neil, GP)

More broadly, the multiple morbidities characteristic of homelessness challenge the functional specialisms of healthcare organizations in an acute way

‘None of their individual needs quite meets any statutory service’s level of them having to respond. So “Yes you have a mental health problem but it’s probably a personality disorder and anyway you’re drinking too much. Yes well, you could come to alcohol services but really while your behaviour is as bad as it is we don’t know what to do you with. And what about your drug use? Yes well, drug services are interested but really they can’t offer you any treatment until you start to think about your alcohol abuse. And what about your behaviour and is there a mental health problem?” So everybody finds reasons not to help you and you get worse’ (Neil, GP)

In the organization of healthcare by health condition, the nature of homeless health cannot be recognised. This is compounded by the nature of medical training:

‘Medicine has become much more compartmentalised, training’s more finite, so people are only trained in often quite narrow [ways]... I think the health service tends to work ... there’s often a tendency for people to hand stuff off, to say ‘that’s not us, that’s not our team, that’s something else’ And I think particularly homeless people or people who are marginalised can often end up getting lost in the process’ (Will, GP)

These problems are especially acute as homeless health must stretch across different bureaucracies of health and social care, and are exacerbated by the internal market between services:

'You get big multi-agency meetings of people all saying "Yeah but he's not my responsibility for the following reasons" and with the funding cuts they come to these meetings lanyered-up ... everybody has got high-level legal reasons to support them not helping this person ... the last thing they want to do is even approach a patient. What they talk about is getting their 'fingerprints' on them, because once that happens any other social services department will say 'Oh no, well, Borough X is already dealing with this so refer to Borough X' (Neil, GP)

In this context, there is literally no place for the homeless person in the healthcare system

'We didn't even keep notes on them, the person in charge of them was a housing operative (sic) that no-one knew even worked here. And in the end it was comfortable because it was the status quo' (Neil, GP)

The homeless may not exist as 'a patient' at all, may be 'out of order' in established organization. Even when admitted to hospital, long-term care is compromised by expectations regarding personal and social resources (housing, literacy, motivation). Patients are discharged onto the streets *'kind of setting them up to fail really again'* (Ryan, GP). In this context homeless people may have *'Low motivation to do the work that it takes to be a patient 'why would you bother?'* (Liam, Consultant)

How is organization part of the solution? *I thought 'how would you do this from scratch, from a patients' perspective with no voice and who couldn't complain?'* (Liam, Consultant). In the regional SBS the principle for innovation lay in prioritising care co-ordination across acute and community care and across health and social care, attracting additional funds to an existing GP practice

The average homeless person will come to our drop-in clinics and they'll come and see us for some general medical stuff and a sick note. They'll have an alcohol problem and a drug problem, they'll have Hepatitis C and they'll want to see the nurse with their leg ulcer and so they'll slowly move between all those healthcare professionals in one hour. They'll come in to see me, they'll go out and see their alcohol worker, they'll go out, go and see the drug worker and get their methadone script and then get their leg dressed by the practice nurse' (Ryan, GP)

Or by diversifying organizational form, as London SBS have chosen with the establishment of a charity that allows *'lots of latitude ... so we're not entirely beholden to the NHS'* (Liam, Consultant). In both cases, new routines and job-roles have been established to identify homeless in-patients, establish community health and housing needs and secure support before discharge. This took time to embed – with hospital resistance to 'interference' from GPs and community workers – but is now well established in practice. The hospital informs SBS once a homeless person is admitted:

'... the daily sheet it's called ... after 9am we go on the ward to see anyone who has come in [overnight]... They have got better because before it was like [they'd tell us] "a patient has been discharged" at the last minute ... it doesn't happen as often now, so they do double check and make sure there is actually an address and if not we are called' (Jess, Care Navigator)

This is supported with new roles, established to carry out co-ordination. Whilst the concept of 'care navigators' is not unique, in SBS the role crosses a particularly wide range of services, from housing to benefits, primary care and all secondary specialisms. It is also distinguished here as only ex-homeless staff are appointed:

'Homeless people were so dispossessed and so fractured as human beings that they couldn't connect with other people although we share living human forms. They've been in places, you have no idea. ... So I thought let's train homeless people to become care navigators. That's what we did.' (Liam, Consultant)

The organization of this new skill mix has been purposefully non-hierarchical

I came in from a background of homelessness and from drinking and things for 20 years ... we are a team, and the doctor talks to me, he doesn't ever talk down, he talks to me and always involves [me]' (Jess, Care Navigator)

By developing guidelines for homeless health and establishing a new Faculty of Inclusive Health, (an independent, multi-disciplinary body focused on health care for homeless and excluded people), SBS aims to spread its approach to homeless health

'The reason for the Faculty is it gives you societal endorsement ... before you knew it the standards had become the standards for the NHS' (Liam, Consultant)

Following the London example, SBS supports a further 11 homeless health teams, replicating their work across the country. By changing the service that is provided, they deliver healthcare to a population previously disregarded:

'People always talk about this population as hard to engage; they're not hard to engage, because they're always in my room, you know? They come – if you give them the right conditions they come' (Ryan, GP)

Concluding Discussion

Seen through the lens of organizational theory, our case studies begin to show how organizational forms and practices are implicated as social determinants of health and, in turn, of health inequalities. Even in a 'universal' healthcare system – with all its advantages – healthcare systems do not work equally well for all. Beyond questions of access, our case studies show that the UK healthcare system is preferentially premised on a 'patient' with a clear clinical pathology and/or who is well-able and well-motivated to maximise public resources, whose socio-economic circumstances support the work that it takes to be ill (good housing, strong social networks, and so on). It is not just that those with socioeconomic advantages are able to get more from the healthcare system (the 'middle-class maximiser' phenomenon). Our more fundamental claim, supported by the case studies, is that the system is designed for an 'ideal abstract patient', defined by clinical specialisms and with privileged economic and social assets. Whilst health inequalities research positions health care organizations as neutral (if only by default), the innovations described above reveal the partiality of this position by starting from the perspective of those people who do not possess those assets. . The patient is not – to paraphrase Acker (1990) – 'a universal being' (p.150). This is health and illness viewed from elsewhere: a standpoint epistemology that comes from the empathetic ethnographic experience of healthcare professionals, and those who work with them.

In the spirit of Acker, the case studies demonstrate that the design of services is abstracted from social circumstance and is specifically embodied (rather than disembodied), premised on clearly defined needs that – at their most ideal – fall within clinically and bureaucratically categories. Many patients who do not conform to this ideal – including some who do possess economic and social advantages - are faced with negotiating across boundaries to seek care, and may receive excellent support from health care professionals to do so. However, it is also clear from our case studies that this does not always happen, can be a particular problem for those with the fewest assets, and that effective intervention demands organizational change. Whilst our case studies are

not empirically representative, they suggest four key areas for change. First, horizontal integration across services, within healthcare and between health and social care extended to include the housing and welfare benefits systems. Second, new posts to support the everyday work of integration., the development of new organizational artefacts such as, for example, the NFA (No Fixed Address) ‘flag’ on patient records and the social prescribing referral form that structure integration in everyday work. Fourth, new organizational practices that support the integration of a wider range of voices – patients, community and staff – into the design and delivery of services. In various ways, each of these has been suggested elsewhere as means to address health disadvantage (for example WHO 2008; Health Education England 2016; Bowling et al 1993). Our point, however, is that each solution is aimed towards just one manifestation of a more structural problem, namely that the organization of healthcare privileges those who can best accommodate to its implicit ‘patient’ and these are more likely to be those who are already more advantaged in terms of social, economic and cultural capital. In our case studies, additional posts have been funded independently, from beyond the NHS, but if such interventions were to be more widely effective, they would demand NHS resources which might be seen as a redistribution of resources away from those who conform more closely to the abstract ideal patient, although whether this would be the case given the potential for early intervention to make long term savings is an unresolved point at present.

From the achievements described above, we learn more about what it takes to bring about change aimed at tackling health inequalities. Both innovations were driven by a ‘cause’ that came to stand for what is wrong with the organization of care (see Fuller et al 2018 for further details). The ambivalent position of NHS staff as healthcare insiders and empathetic ethnographers at the front-line with those most in need shows that it is not just *‘intellectual capital’* that is in play (as Keogh suggests) but the ability to see ‘both ways’, from beyond and into the healthcare system, although this alone is not enough. It is notable that both innovations were begun by doctors, relatively privileged employees within the healthcare sector. We sought case studies led by cleaners, porters or care assistants but could not find any, although we hope these exist ‘under the radar’. However, our case studies suggest that innovation may be a privilege of the relatively powerful, those with some autonomy in time management and the confidence and security to think through how things might be otherwise, and who can assemble the resources required to innovate (staff, funding, buildings, powerful allies and so on).

Nonetheless, it is notable that whilst both case studies began in the NHS neither is now fully-within, or fully funded by the NHS, which was repeatedly described as being too fixed, too slow and too cash-strapped to support change of this kind. This raises questions about the future for organizational intervention in health inequalities. On the one hand, it suggests that the NHS must make a strategic intervention if the latent resource of staff innovation is to be realised. Three steps might facilitate this. First, the development of a language and culture that endorses incremental and bottom up change (in a context where ‘innovation’ is currently associated with top-down change). Second, education and training that builds staff capability for reflexive practice and multi-disciplinary working. Third, leadership that supports experimentation and evaluation, extends ‘user engagement’ and is able to generate funding for initiatives across pre-existing siloes. On the other hand, it may be that hybrid organizations, including the kind illustrated by our case studies, offer the greatest capacity for innovation through their ability to mobilise of diverse resources beyond the constraints of the NHS. However, to return to where

we started this paper, such is the challenge of health inequalities that we hope both routes are possible. It is not that the organization of healthcare is the underlying cause of health inequalities. However, we have shown that advantage – and disadvantage – are embedded in the organization of healthcare, such that re-organization may have an important effect on life chances. The nature of organization is not separate from the way inequalities operate, but is entwined with them.

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